



Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: DOCTORS HOSPITAL OF LAREDO 3255 W PIONEER PARKWAY ARLINGTON TX 76013	MFDR Tracking #: M4-07-8098-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: TEXAS MUTUAL INSURANCE CO Box #: 54	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This claim has been partially reimbursed; however, it was not paid at what we determine as a fair and reasonable amount. This is an outpatient surgery and understanding TWCC wants to move to a hospital reimbursement based on Medicare, we are asking for %-over-Medicare. We have found 140% of the Medicare allowable is fair and reasonable and has been accepted by most carriers."

Amount in Dispute: \$4,016.13

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The problem with the requestor's proposed fee is:

- The requestor has failed to show that a fee less than its \$5,014.03 would not ensure access to care.
- The requestor has failed to show that its methodology for producing a fee at a percentage of billed charges would achieve effective medical cost control.
- The requestor has failed to show that its method for producing a fee greater than that of Medicare meets the standard to pay no more than is paid for persons of an equivalent standard of living.
- The requestor has failed to show that a proposed fee less than \$5,014.03 would not guarantee increased security of payment.
- The requestor has failed to show that its approach will yield similar payment for similar services.
- The requestor proposal failed to meet the requirements of DWC Rule 134.1(d)(3).
- The requestor proposed fee exceeds known fair and reasonable amounts.

Given the above Texas Mutual does not believe the requestor has proven that its proposed fee is fair and reasonable nor is due any additional payment beyond that amount that was paid."

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
11/14/06	CAC-W10, CAC-W4, CAC-143, 420, 713, 719, 891, 894	Outpatient Surgical Fees	\$4,016.13	\$0.00
			Total Due:	\$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code § 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.1, titled *Medical Reimbursement*, effective May 2, 2006 set out the reimbursement guidelines.

This request for medical fee dispute resolution was received by the Division on August 15, 2007.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason code:
 - CAC-W10-No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology
 - CAC-W4-No additional reimbursement allowed after review of appeal/reconsideration
 - CAC-143-Portion of payment deferred.

- 420-Supplemental payment
 - 713-Fair and reasonable reimbursement for the entire bill is made on the 'O/R service' line item.
 - 719-Reimbursed at carrier's fair & reasonable. Cost data unavailable for facility. Additional payment may be considered if data is submitted.
 - 891-The insurance company is reducing or denying payment after reconsideration
 - 894-Fair and reasonable reimbursement for the entire bill is made on the "O/R service" line item.
2. This dispute relates to outpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.1, effective May 2, 2006, 31 TexReg 3561, which requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
 3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
 4. Division rule at 28 TAC §133.307(c)(2)(F)(iv), effective December 31, 2006, 31 TexReg 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include a position statement of the disputed issue(s) that shall include "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the requestor's documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of Division rule at 28 TAC §133.307(c)(2)(F)(iv).
 5. Division rule at 28 TAC §133.307(c)(2)(G), effective December 31, 2006, 31 TexReg 10314, applicable to disputes filed on or after January 15, 2007, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:
 - The requestor's position statement states that "This claim has been partially reimbursed; however, it was not paid at what we determine as a fair and reasonable amount. This is an outpatient surgery and understanding TWCC wants to move to a hospital reimbursement based on Medicare, we are asking for %-over-Medicare. We have found 140% of the Medicare allowable is fair and reasonable and has been accepted by most carriers."
 - The requestor does not discuss or explain how payment of \$4,016.13 would result in a fair and reasonable reimbursement.
 - The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
 - The requestor did not discuss or explain how payment of the requested amount would satisfy the requirements of Division rule at 28 TAC §134.1.
 - The requestor did not discuss or support that the proposed methodology would ensure that similar procedures provided in similar circumstances receive similar reimbursement.
 - The requestor did not submit nationally recognized published studies, published Division medical dispute decisions, or documentation of values assigned for services involving similar work and resource commitments to support the proposed methodology.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

6. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307(c)(2)(F)(iv) and §133.307(c)(2)(G). The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code §133.307, §134.1
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

_____	_____	October 28, 2010
Authorized Signature	Medical Fee Dispute Resolution Manager	Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.